Health Care Alert: ODM Seeks Federal Approval to Waive Regulatory Requirements, Amend State Plan

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On April 14, 2020, the Ohio Department of Medicaid (ODM) submitted a request for the federal Centers for Medicare & Medicaid Services (CMS) to approve a State Plan Amendment (SPA) and waivers of specified regulatory requirements, including certain requirements applicable to Section 1115 waiver services. If approved, the requested changes will be retroactive to March 1, 2020 and will continue in effect until the end of the federally declared public health emergency.

The ODM submission was extensive. Below is a brief overview of some of the requests, which were submitted to CMS. This is a general summary of the requests, and the implementation may include more detailed requirements, which are not covered in this *Health Care Alert*.

With respect to services authorized under the SPA, ODM requested authority during the COVID-19 pandemic to (among other things):

- Allow hospitals to make good faith presumptive eligibility determinations;
- Suspend all cost sharing requirements for Medicaid enrollees;
- Allow flexibilities in telehealth;
- Expand prior authorization for medications to allow automatic renewal without clinical review;
- Waive limits to the number of bed hold days for nursing facility residents and individuals living in ICFs for individuals with intellectual disabilities;
- Waive prior authorization requirements in Medicaid fee for service, and managed care plans including but not limited to:
  - Pre-certification for hospital services
  - DME
  - Home health services
  - Pharmacy benefits
  - Behavioral health

  - In-home physician visits;
- Waive Pre-Admission screening and Annual Resident Review (PASRR) in person requirements;
- Suspend screening requirements for provider enrollment, including payment of the application fee, criminal background checks, site visits, and in-state licensure requirements;
- Allow facilities, hospitals, and individual practitioners to provide services in alternative settings, such as hotels, dormitories, or temporary shelters;
- Suspend provider re-validation and renewal efforts;
- Waive penalties under the Emergency Medical Treatment and Labor Act (EMTALA) where transfers are necessary to avoid transmission of COVID-19 and allow EMTALA screenings to be conducted via telehealth;
- Defer in-person or face-to-face service requirements for the state plan Home Health Benefits, including DME;
- Waive TPL cost avoidance procedures for providers utilizing the broader authorized telehealth services;
- Remove limits on Private Duty Nursing post hospital benefit and remove limits on home health services per day and week;
- Allow Providers to accept a verbal authorization, and to instead, document the date time and location of the verbal consent on applications for Medicaid benefits;
- Waive requirements for face-to-face evaluation, new physician order, and new medical necessity documentation for DME that is lost, destroyed;
- Allow licensed prescribers not currently enrolled in Medicaid to prescribe medically necessary DMEPOS services;
- Waive signature requirement for proof of delivery of DME;
- Allow and accept verbal statements when a provider is unable to obtain written acknowledgement for Hospice services;
- Allow the use of remote technology and recorded media for clinicians and assistive technology professionals to conduct assessments for the dispensing of complex rehabilitation wheelchairs and accessories;
- Waive in person or face to face requirements for any state plan service or assessment necessary to prevent virus transmission;
- Waive signature requirements for proof of service delivery for home health and private duty nurses; and
- Remove the requirement for RN coverage on-site 24-hour per day, seven days a week while ventilator-weaning services are provided if the nursing facility has a respiratory care professional or respiratory therapist available in the facility 24-hours per day, seven days a week.

With respect to DODD waiver services, ODM requested authority during the COVID-19 pandemic to (among other things):

- Temporarily exceed service limitations with regards to current funding limitations under the Individual Options (IO) and Level One waivers, waive limitations on respite services under the SELF waiver, and waive prior authorizations under the IO waiver;

- Expand service settings to allow adult day services (ADS) and vocational habilitation (Voc Hab) providers to furnish services in residential settings and remotely;
- Under certain circumstances, allow ADS and Voc Hab services to extend to those times when the individual is not physically present;
- Permit payment for direct care services rendered to minor children by family caregivers or legally responsible individuals who are employed by an agency;
- Modify provider types to allow ADS and Voc Hab providers to receive certification in HPC, Respite and Participant-Directed HPC;
- Modify licensure or other requirements for settings where waiver services are furnished;
- Permit flexibility with pre-certification and on-site visits;
- Add flexibility with corrective actions plan timelines; and
- Allow level-of-care evaluations (and re-evaluations) and service planning to be accomplished by email or telephone.

With respect to Ohio Department of Aging and ODM waivers, ODM requested authority during the COVID-19 pandemic to (among other things):

- Expanding service settings where services may be furnished including but not limited to personal care, adult day and out of home respite;
- Allow the use of unapproved living units in ODA-certified assisted living facilities;
- Permit payment for direct care services rendered by family caregivers and legally responsible individuals when not already approved on the waiver;
- Modify provider qualifications to allow providers with an active Medicaid ID to furnish waiver services across delivery systems and temporarily waive background checks for new providers;
- Modify the process for level of care evaluations and reevaluations to allow flexibility with required timelines
    - A list of “late” assessments must be provided monthly;
- Allow the face to face level of care assessment requirement to be replaced with telephonic or desk reviews
    - The assessment must be validated at the next face to face visit;
- Modify the process of person-centered service plan development to allow flexibility with required timelines;
- Allow face to face person centered service plan development, service authorization and adjustment to take place by telephone
    - Excludes home maintenance and chore services, and home modifications;
- Allow service plans to be authorized for up to 90 days or until the next face-to face contact;
- Allow verbal consent to the service plan with signature to be obtained at the next face to face visit; and
- Allow flexibility with required timelines for incident reporting as long as the rationale for the delay is documented.

If you have questions about these requested changes and their potential impact on your organization, please contact Suzanne Scrutton, Robin Amicon, Robin Canowitz or your regular Vorys attorney.

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Vorys COVID-19 Task Force

Vorys attorneys and professionals are counseling our clients in the myriad issues related to the coronavirus (COVID-19) outbreak. We have also established a comprehensive Coronavirus Task Force, which includes attorneys with deep experience in the niche disciplines that we have been and expect to continue receiving questions regarding coronavirus. Learn more and see the latest updates from the task force at vorys.com/coronavirus.